**You must return this form.**

Basic Health™

# Recertification Form

**You must fill out, sign, and date this form. To continue your health care coverage, Basic Health must receive this form and all required documentation by the due date below.**

[date letter is generated]
**Response due to Basic Health by** [due date]

[BARCODE]

I.D. #: [SSN]

[GROUP I.D. & LANGUAGE CODE]



1. Write your current street address, if different from above:

_____
Street address City State ZIP code

2. Are you or your spouse self-employed or do you have rental income? ❑ Yes ❑ No
   If you are self-employed, write your Unified Business Identifier (UBI) number here _____ .
   Your UBI number is a nine-digit number found on your Master Business License. For questions about UBI numbers, call the Department of Licensing (DOL) at 360-664-1400.
   ❑ Check here if you do not have a UBI number because your business is not registered with the DOL.

3. List the first and last names of your spouse and children, if any, even if they are not enrolled in Basic Health (BH).
   Spouse _____
   Child(ren) _____
   _____

**I understand that:**

- I must report changes in my job or other sources of income (such as a new job or promotion, going from part-time work to full-time work, or a change in child support or other income) within 30 days of the end of the first month at the new income level.
- I must send proof of my gross family income (before taxes) when requested by BH or when reporting a change.
- I must report address changes and changes in my family (for example, a marriage or divorce, the birth of a child, or a child who leaves the home or is no longer a dependent or full-time student) within 30 days of the change.
- BH may check information through contact with other state or federal agencies about my family's income, Washington State residence, eligibility for Medicare, and any other information needed to verify my eligibility for enrollment in BH.
- My signature on this form authorizes BH to use the information provided to verify my family income or eligibility with other agencies or my employer.

I authorize my family's current or former health plan(s) or medical provider(s) to give BH any non-medical records that are necessary for participation in BH, for the persons signing below and for my children under age 18. This authorization will continue for as long as I remain enrolled in BH.

The information I have given in this form and the documents I'm enclosing is true, correct, and complete to the best of my knowledge. I understand that if I withhold information or give BH false or misleading information, my family and I will lose coverage. BH may also bill me for up to two times the amount the state paid for my family's coverage. If I have given false information, BH may prosecute me for perjury or charge me for services received through fraud. If I am billed for past premiums or penalties but do not pay, the state may refer me for collection or bill my estate.

**Must be signed by you and your spouse**

| X _____ | _____ | X _____ | _____ |
|---|---|---|---|
| Your signature | Date | Spouse's signature | Date |

**Signature of all children age 18 and over who receive Basic Health coverage**

| X _____ | _____ | X _____ | _____ |
|---|---|---|---|
| Signature | Date | Signature | Date |

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's (the agency that administers Basic Health) Privacy Notice is available upon request by calling 360-923-2822 or go online **www.hca.wa.gov**.